SCHAEFFERSTOWN
MENNONITE HIGH SCHOOL

301 NORTH CARPENTER STREET, P.O. BOX 327, SCHAEFFERSTOWN, PA 17088
PHONE: (717) 964-8140 E-MAIL: office@smhigh.org

MEDICAL RELEASE STATEMENT

Dear Parent,

During this school year your child may require medical care from the nurse of the ELCO School District, a local doctor, or treatment in the emergency room of one of the local hospitals. If your child becomes ill at school, you may be asked to come and pick them up.

If you are willing to have your child receive the above services as long as they are enrolled, please sign the following release. If you have a preference as to a doctor or hospital, please specifically note this at the bottom of this release. Also note any other information not included on the PHYSICAL EXAMINATION form which may be useful to the school office.

Thank you for your cooperation.

Randall Hoover, *Administrator*

Since my child is under the legal age of 18 we, the undersigned, do hereby give written consent for any hospitalization, medical and/or surgical treatment that may be considered necessary by the attending physician, or a responsible staff person while enrolled as a student at Schaefferstown Mennonite High School and do hereby release its staff and Board of Directors from any liability arising out of said referral and treatment. In any case, we understand that the school will make every effort to contact us if or when an emergency arises.

_____ _____
GUARDIAN/FATHER'S SIGNATURE MOTHER'S SIGNATURE

COMMENTS

STUDENT'S NAME: _____ TERM: _____-_____

PREFERRED DOCTOR: _____ PHONE: ( )_____-_____

PREFERRED HOSPITAL: _____

OTHER: